

BOARD OF REGISTERED NURSING

P.O Box 944210, Sacramento, CA 94244-2100

P (916) 322-3350 | www.rn.ca.gov

Ruth Ann Terry, MPH, RN, Executive Officer



EXPERT WITNESS APPLICATION

The Board of Registered Nursing is seeking qualified registered nurses with the professional and educational background to develop opinions, prepare written reports and/or testify as Expert Witnesses on their behalf. An Expert Witness is any person possessing technical or professional knowledge from advanced education and/or extensive work experience enabling the formation of definite opinions in an area of expertise. If you wish to provide this service to your community and be considered by the Board as an Expert Witness, please complete all sections of the application and submit to the above address, ATTN: Expert Witness Program. In addition, **please attach your Curriculum Vitae (resume).**

An Expert Witness must hold a current and active license in good standing with no prior disciplinary actions or convictions.

It is imperative that you have at least five years of experience and current skills in the area of expertise for which you will be reviewing cases and rendering a professional opinion. Please select (✓) the applicable area(s) for which you are most knowledgeable, keeping in mind that you will need to defend your position in court should you be called to testify.

California Civil Code Section 43.8, provides immunity for those practitioners who render an opinion against a registered nurse for the Board.

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|--|---|---|
| <input type="checkbox"/> Medical/Surgical | <input type="checkbox"/> OB/GYN/L&D | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Psych/Mental Health | <input type="checkbox"/> Operating Room | <input type="checkbox"/> PACU/Recovery Room |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> OP/Ambulatory/Clinic | <input type="checkbox"/> Oncology/Hospice |
| <input type="checkbox"/> Emergency Room | <input type="checkbox"/> AIDS | <input type="checkbox"/> Pediatric ICU |
| <input type="checkbox"/> CCU/Telemetry | <input type="checkbox"/> Critical Care-Adult | <input type="checkbox"/> Home Health |
| <input type="checkbox"/> Neonatal ICU | <input type="checkbox"/> LTC/SNF/Geriatrics | <input type="checkbox"/> Corrections |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Risk Mgmt/QA |
| <input type="checkbox"/> Nurse Anesthetist | <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Nurse Midwife |
| <input type="checkbox"/> Other: _____ | | |

Please Print or Type Clearly

Full Name:			Birthdate:
Last	First	Middle	
Home Address:			Zip Code
Street	City	State	
Business Address:			Zip Code
Street	City	State	
Home Phone:	Business Phone:	Cell Phone:	Email Address:
California RN License No.:	Other Professional Licenses & States of Licensure:		
I certify under the penalty of perjury under the laws of the State of California that all statements, answers and representations in this application including all attachments are true and accurate.			
Signature of Applicant: _____			Date: _____